

Your Pharmacy Benefits

	Wellness Health Plan	Regular Health Plan	Consumer Focused Health Plan (HSA Eligible)
RETAIL - 30 DAY SUPPLY			
Tier 1	\$5 copay	\$5 copay	20% after deductible
Tier 2	\$30 copay	\$30 copay	20% after deductible
Tier 3	\$50 copay	\$50 copay	20% after deductible
MAIL ORDER - 90 DAY SUPPLY (OR RETAIL)			
Tier 1	\$10 copay	\$10 copay	20% after deductible
Tier 2	\$60 copay	\$60 copay	20% after deductible
Tier 3	\$100 copay	\$100 copay	20% after deductible
Pharmacy Out-of-Pocket Maximum	\$2,000 - individual \$4,000 - family	\$2,000 - individual \$4,000 - family	Included in the medical out-of-pocket maximum

Wellness Health Plan ONLY	
DIABETIC, HYPERTENSION AND HIGH CHOLESTEROL PRESCRIPTIONS	
RETAIL - 30 DAY SUPPLY	
Tier 1	No copay
Tier 2	\$15 copay
Tier 3	\$30 copay
MAIL ORDER - 90 DAY SUPPLY (OR RETAIL)	
Tier 1	2 Times the 30-day supply
Tier 2	
Tier 3	

Wellness and Regular Health Plans Pharmacy Out-Of-Pocket Maximums

For each covered prescription, you pay the copay listed for each 30-day or 90-day supply. Effective 7/1/2015 the out-of-pocket maximum for pharmacy is \$2,000 individual and \$4,000 family. The pharmacy out-of-pocket maximum limits are in addition to the medical out-of-pocket maximums on page 28-29.

Once the out-of-pocket maximum has been met for pharmacy co-pays, all prescriptions covered under the plan will be paid 100% by the plan.

Consumer Focused Health Plan

1. If your medication is on the UHC Preventive Drug List, you pay the copay. Your copay will apply towards your annual out-of-pocket maximum. After your limit is met, the plan pays 100% of your costs. Go to Employee Wellness & Benefits Resources found at link.nebraska.gov to view the UHC Preventive Drug List.

Consumer Focused Health Plan ONLY	
UHC PREVENTIVE DRUG LIST (FORMULARY) Go to link.nebraska.gov; Wellness & Benefits Resources page for list	
RETAIL - 30 DAY SUPPLY	
Tier 1	No copay
Tier 2	\$25 copay
Tier 3	\$50 copay
MAIL ORDER - 90 DAY SUPPLY (OR RETAIL)	
Tier 1	2 Times the 30-day supply
Tier 2	
Tier 3	

2. For all other covered prescriptions, the full cost of the prescription is applied towards your deductible. Once you meet your deductible, then you pay 20% coinsurance until your annual out-of-pocket limit is met. Then all costs are paid 100% by the plan.

Diabetic Supplies

Diabetic supplies covered under the prescription drug benefit include syringes, needles, lancets, blood monitor kits, test strips, blood glucose calibration solutions, urine tests, and blood test strips. Blood glucose monitors are also covered under the pharmacy benefit, but continuous blood glucose monitors are currently excluded. Insulin pumps and sensors are covered under the medical benefit as Durable Medical Equipment. If you have any questions, call customer service at 877-263-0911.

QUICK REFERENCE GUIDE 2015-16 Health Benefits



Medical, Dental & Vision Premiums

The monthly premiums for your medical, dental, and vision plans for July 1, 2015 through June 30, 2016 are shown below.

The State contributes 79% of the total cost of your health care benefits for full-time employees.

Premiums are deducted from your paycheck pre-tax. That means the premiums are deducted from your pay before taxes are withheld and thus, you do not pay taxes on these premiums.

It is your responsibility to review your pay stub to ensure that the proper deductions are taken. You are responsible for the cost of the proper employee share of your elected benefits. A payroll error does not absolve you of responsibility for payment of the proper share of the cost.

NOTE:
For employees who are paid bi-weekly, your deduction will be half of the total shown here and deductions are only taken 24 times per year.

Monthly Medical Plan Premiums

		Wellness Health Plan		Regular Health Plan		Consumer Focused Health Plan	
		FULL-TIME	PART-TIME	FULL-TIME	PART-TIME	FULL-TIME	PART-TIME
Employee Only (Single Coverage)	Your Cost:	\$107.56	\$176.34	\$129.00	\$211.50	\$73.48	\$120.46
	State Cost:	\$404.66	\$335.88	\$485.30	\$402.80	\$276.40	\$229.42
	Total:	\$512.22	\$512.22	\$614.30	\$614.30	\$349.88	\$349.88
Employee + Spouse (Two-Party Coverage)	Your Cost:	\$285.04	\$467.34	\$341.86	\$560.48	\$194.70	\$319.22
	State Cost:	\$1,072.34	\$890.04	\$1,286.02	\$1,067.40	\$732.48	\$607.96
	Total:	\$1,357.38	\$1,357.38	\$1,627.88	\$1,627.88	\$927.18	\$927.18
Employee + Dependent Children (Four-Party Coverage)	Your Cost:	\$220.50	\$361.52	\$264.46	\$433.58	\$150.62	\$246.94
	State Cost:	\$829.54	\$688.52	\$994.86	\$825.74	\$566.64	\$470.32
	Total:	\$1,050.04	\$1,050.04	\$1,259.32	\$1,259.32	\$717.26	\$717.26
Employee + Spouse + Dependent Children (Family Coverage)	Your Cost:	\$381.86	\$626.06	\$457.96	\$750.84	\$260.84	\$427.64
	State Cost:	\$1,436.52	\$1,192.32	\$1,722.80	\$1,429.92	\$981.24	\$814.44
	Total:	\$1,818.38	\$1,818.38	\$2,180.76	\$2,180.76	\$1,242.08	\$1,242.08

Monthly Dental Plan Premiums

	Basic Option	Premium Option
Employee Only (Single Coverage)	\$22.44	\$26.20
Employee + Spouse (Two-Party Coverage)	\$44.92	\$52.44
Employee + Dependent Children (Four-Party Coverage)	\$64.72	\$75.60
Employee + Spouse + Dependent Children (Family Coverage)	\$70.32	\$82.12

Monthly Vision Plan Premiums

	Basic Option	Premium Option
Employee Only (Single Coverage)	\$5.14	\$7.96
Employee + Spouse (Two-Party Coverage)	\$8.26	\$12.78
Employee + Dependent Children (Four-Party Coverage)	\$8.42	\$13.02
Employee + Spouse + Dependent Children (Family Coverage)	\$13.56	\$21.00

Your Health Insurance Benefits

Wellness Health Plan		
In-Network		Out-of-Network
\$600 individual \$1,200 family		\$1,200 individual \$2,400 family
\$2,400 individual \$4,800 family		\$4,800 individual \$9,600 family
\$2,000 individual \$4,000 family		
		30% after deductible
\$25 copay		
\$35 copay		
Plan pays 100%		
Plan pays 100%		
Paid at 100% up to \$500; then 20% after deductible		
20% after deductible		Not covered
20% after deductible		
\$35 copay		
		Covered at 30% per Patient Protection and Affordable Care Act (PPACA) guidelines. If services are outside of National Health Care Reform guidelines, they are not covered.
Covered at 100% per Patient Protection and Affordable Care Act (PPACA) guidelines. There are no age restrictions on preventive screenings.		
Plan pays 100%		30% after deductible
Plan pays 100%		
\$35 copay		30% after deductible
20% after deductible		
20% after deductible		30% after deductible
20% after deductible		30% after deductible
\$25 copay		
\$35 copay		30% after deductible
\$25 copay		
20% after deductible		30% after deductible

Plan Year Deductible (must be satisfied before coinsurance is paid)
Annual Medical Out-of-Pocket Maximum (deductible, coinsurance, & medical co-pays)
Annual Pharmacy Out-of-Pocket Maximum
PHYSICIAN OFFICE VISITS
Primary Care Physician Office visit
Specialty Office visit
Allergy testing / serum
Allergy shots
Pathology Services
Surgery, Deliveries, Radiology & Pathology (office)
Chemotherapy/Radiation Therapy
Routine Vision Exam plus Refraction
PREVENTIVE EXAMS
Flu Shots
Annual exams (includes foot exams for diabetics)
Immunizations - Child & Adult
Pneumococcal immunizations
Routine pre-natal visits
Well baby exams
Diabetes vision screening
Mammogram
Pap smear
Colonoscopy
Prostate cancer screening
EMERGENCY CARE
Ambulance
Urgent care center
Hospital emergency room
HOSPITAL SERVICES
Inpatient hospital
Ambulatory Surgical Center
Approved skilled nursing facility
Outpatient hospital services (diagnostic lab., radiology)
Durable medical equipment
Home health care, Hospice care
BEHAVIORAL HEALTH SERVICES
Inpatient
Outpatient
OTHER SERVICES
Chiropractic Office visit (Limit 60 sessions per year)
Therapy - Occupational, Physical, Speech (Limit 60 sessions per year)
Hearing aids & exam (Limit \$1,500 every 3 years)

Regular Health Plan	
In-Network	Out-of-Network
\$1,000 individual \$2,000 family	\$2,000 individual \$4,000 family
\$4,000 individual \$8,000 family	\$8,000 individual \$16,000 family
\$2,000 individual \$4,000 family	
\$30 copay	40% after deductible
\$40 copay	
20% after deductible	
Not covered	
Covered at 100% per Patient Protection and Affordable Care Act (PPACA) guidelines. If services are outside of National Health Care Reform guidelines, they are not covered.	Covered at 40% per Patient Protection and Affordable Care Act (PPACA) guidelines. If services are outside of National Health Care Reform guidelines, they are not covered.
Not covered	
20%; deductible waived	
\$50 copay	40% after deductible
20% after deductible	
20% after deductible	40% after deductible
20% after deductible	40% after deductible
\$30 copay	
20% after deductible	40% after deductible
20% after deductible	40% after deductible

Consumer Focused Health Plan (HSA Eligible)	
In-Network	Out-of-Network
\$2,600 individual \$5,200 family	\$5,200 individual \$10,400 family
\$4,100 individual \$8,200 family	\$8,200 individual \$16,400 family
Included in the medical out-of-pocket maximum	
20% after deductible	40% after deductible
Not covered	
Covered at 100% per Patient Protection and Affordable Care Act (PPACA) guidelines. If services are outside of National Health Care Reform guidelines, they are not covered.	Covered at 40% per Patient Protection and Affordable Care Act (PPACA) guidelines. If services are outside of National Health Care Reform guidelines, they are not covered.
Not covered	
20% after deductible	
20% after deductible	40% after deductible
20% after deductible	
20% after deductible	40% after deductible
20% after deductible	40% after deductible
20% after Deductible	40% after Deductible

Watch for Your NEW Health Insurance Cards in the Mail

You can print your own card on www.myUHC.com starting on July 1, 2015 or after your benefits effective date.



Make sure to update your insurance card information with your Pharmacy. Claims may be denied if your information is not current.

IMPORTANT INFORMATION: This document provides a general summary of basic benefit plan provisions and is not a substitute for the official documents. If there are any inconsistencies between this summary and the official plan documents, the plan document will prevail. Please refer to the summary plan documents found on Employee Wellness & Benefits website under link.nebraska.gov for exact benefits, exclusions and limitations.